DRVD INVESTIGATION REPORT

AN INVESTIGATION INTO THE DEATH OF JN

52-year-old female, died from Hydrocodone, Promethazine, and Paroxetine toxicity with contributing hypertrophic cardiomyopathy while incarcerated at the Lynchburg Adult Detention Center Annex.

DRVD CASE #00-0158
Department for Rights of Virginians with Disabilities

I. Summary of Facts

JN, a 52-year-old female, died while an inmate at the Lynchburg Adult Detention Center. JN was committed to the custody of the Lynchburg Adult Detention Center at approximately 2:28 a.m. on February 11, 2000. She was found unresponsive in her cell at approximately 8:42 a.m. and was pronounced dead in the Lynchburg General Hospital emergency room at approximately 9:26 a.m. the same day.

II. Summary of Findings

The failure of the Lynchburg Adult Detention Center (which is operated by the Blue Ridge Regional Jail Authority (BRRJA)) to follow its own policies and procedures resulted in a failure to provide JN adequate services and ensure a safe environment and met the legal definition of neglect.

III. Methodology

The Department for Rights of Virginians with Disabilities conducted this investigation of an alleged incident of abuse or neglect of an individual with mental illness pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 *et. seq*.) ("the Act").

This investigation included a review of the following documents and records:

1. Medical records obtained from Lynchburg General Hospital and Amherst Family Practice;

2. Serious Incident Report from the Blue Ridge Regional Jail Authority including statements of witnesses;

3. Standard Operating Procedures obtained from the Blue Ridge Regional Jail Authority; and

4. Medical examiner's report and autopsy of JN.

IV. Facts

A. Prior to February 11, 2000

JN had a history of hypertension, migraine headaches, chronic pain syndrome, depression, anxiety, and alcohol abuse. She was a "retired" nurse who had a history of apparent drug-seeking behavior at her local hospital emergency room and with her primary care provider. She had recently been taking numerous prescribed medications including methocarbamal, hydrocodone, lotensin, orphenadrine, alprozolam, promethazine, paxil, trazadone, and cyclobenzaprine, at the time of her incarceration. JN also had a history of legal troubles including arrests for petty larceny.

B. Chronology of Events of February 11, 2000 from approximately 2:28 a.m. to 9:26 a.m.

- On February 11, 2000 at approximately 2:28 a.m., JN was received for commitment at the Lynchburg Adult Detention Center Annex following her arrest on outstanding warrants.
- Cpl. S accepted JN from Officer C of the Lynchburg Police Department.
- JN was using a cane with her right hand and was carrying a blue bag in her left hand.
- Officer C told Cpl. S that JN had cancer.
- Officer C told Cpl. S that JN was unsteady on her feet.
- Officer C told Cpl. S that JN had not been handcuffed.
- JN stated to Cpl. S that the blue bag contained her medication.
- Cpl. S removed the blue bag from JN's possession.
- Cpl. S noted that the bag contained approximately 10 bottles of medication.
- Cpl. S decided to leave JN in cell A1 while he processed other inmates.
- At approximately 3:00 a.m. Cpl. S could hear JN snoring while sitting up.

- Cpl. S took the blue bag containing JN's medications to the nurse's station at approximately 3:00 a.m.[1]
- There was no nurse on duty at that time.
- At 4:45 a.m. Cpl. S went to cell A1 because he was going to attempt to process JN.
- Cpl. S observed that JN was asleep and snoring loudly.
- Cpl. S called JN's name several times and she woke up.
- Cpl. S observed that JN appeared to be groggy and unsteady.
- Cpl. S asked Officer E to assist him in moving JN from cell A1 to cell D4.
- JN required assistance from both Cpl. S and Officer E in order to stand up.
- Officer E asked JN if she had taken her medications.
- JN responded "yes."
- Officer E asked JN what medication she was taking.
- JN said that she was on high blood pressure medication and a pain medication.
- It took approximately 20 minutes for Cpl. S and Officer E to walk JN to cell D4.
- Cpl. S checked JN two more times before he left at the end of his shift.
- Cpl. S noted on the "pass down" sheet that is exchanged with the oncoming shift "Get Nurse to check meds for [JN]".
- The shift changed at 6:00 a.m.
- At approximately 8:42 a.m. Officer J was notifying inmates who were scheduled for court at 9:00 a.m. and was unable to wake JN from outside her cell.
- Officer J noted that JN was seated on the bunk with her feet on the floor and torso slumped to her right on the bunk.
- Officer J went to the office to get assistance.

[1] The medications that JN had in her possession when received at the jail included orphenadrine (Norflex), promethazine, paroxetine (Paxil), alprazolan (Xanax), cyclobenzaprine, methocarbamol (Robaxin), vicodin (hyrocodone) and lotensin.

- Officer J and Officer L secured the office and booking area and went to JN's cell.
- Officer J and Officer L attempted to wake JN from outside the cell but were unsuccessful.
- Officer J and Officer L entered the cell and again attempted to wake JN and were unsuccessful.
- Officer J and Officer L did not detect any sign of breathing on the part of JN.
- Officer J went to the office to notify Sgt. W and then returned to JN's cell.
- Officer L left JN's cell and went to the office to call the Jail Medical Officer, Nurse N, and then returned to JN's cell.
- Officer L left JN's cell and went to the processing area to get a Polaroid camera and then returned to JN's cell.
- Officer L took three photographs of JN.
- Nurse N was on duty from 6:30 a.m. to 3:30 p.m. on February 11, 2000.
- Nurse N was called by Officer L at approximately 8:48 a.m..
- Nurse N arrived at the Adult Detention Center Annex "within a couple of minutes".
- Nurse N noted that JN was face down on her bunk.
- Nurse N and Officer L turned JN onto her back.
- Nurse N checked JN's vital signs.
- Nurse N noted that JN was warm to the touch but that her lips, neck, face, and feet were blue.
- The paramedics arrived and started CPR.[2]
- JN was transported to the hospital.
- JN was pronounced dead in the emergency room at approximately 9:26 a.m.

[2] There is no evidence in the record that indicates that any effort at resuscitation was made prior to the arrival of the paramedics.

C. Additional Facts

- An autopsy was performed on JN.
- The cause of death was determined to be hydrocodone, promethazine, and paroxetine toxicity with contributing hypertrophic cardiomyopathy.[3]
- JN had been booked previously at the Lynchburg Adult Detention Center on November 7, 1999.
- The Booking Report dated November 7, 1999 indicates JN's height as 66 inches.[4]
- The Booking Report dated November 7, 1999 includes an "Inmate Medical Receiving/Screening Form".[5]
- The February 11, 2000 Booking Report regarding JN indicates "Received by: L".
- Officer L did not come on duty until 6:30 a.m. on February 11, 2000.
- The February 11, 2000 Booking Report regarding JN indicates her height as 50 inches.
- The Blue Ridge Regional Jail Authority (BRRJA) Standard Operating Procedure regarding medical screening has an effective date of July 1, 1998.
- The BRRJA Standard Operating Procedure regarding medical screening applies to the Lynchburg Adult Detention Center Annex.
- The BRRJA Standard Operating Procedure regarding medical screening provides in pertinent part as follows

  PROCEDURES:

  A. Admission
     1. All inmates are medically screened at the time of admission to the facility.

---

[3] JN was last seen by her primary care provider on February 8, 2000 and no serious health problems were noted. She was also seen by her PCP on February 2, 2000, November 2 and 29, October 4, September 13 and 29, and August 27, 1999. No serious health problems were noted during any of those visits. JN went to the Lynchburg General Hospital emergency room on February 7, 2000 complaining of back pain and a physical examination found her to be a "well-nourished" white female in no acute distress and with no heart anomalies. In fact, JN visited the emergency room 19 times in the 12 months preceding her death and no serious health problems were noted.

[4] The Report of Autopsy indicates JN's length as 67 inches.

[5] The Inmate Medical Receiving/Screening Form used during the booking process of JN on November 7, 1999 is not the form contained in the Blue Ridge Regional Jail Authority Standard Operating Procedure regarding medical screening. The form contained in the Standard Operating Procedure is more comprehensive.

2. The Booking Officer completes a Medical Screening Form if an inmate is admitted when medical staff is unavailable.
    a. The Booking Officer will note the inmate's behavior, appearance, and any other comments the medical staff needs to be aware of.
3. The initial screening may include, but not be limited to:
    a. Assessment of current illnesses, health problems and conditions, and past history of infections or communicable diseases.
    b. Assessment of current symptoms regarding mental health, dental problems, allergies, present medications, special dietary requirements, and venereal disease.
    c. Inquire into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin conditions.
    d. For female inmates, inquiry into possible pregnancy and gynecological problems.

- The BRRJA Standard Operating Procedure regarding Mental Health Inmates (effective date July 1, 1998) provides that the BRRJA shall ensure the safety and welfare of inmates who request or who appear to be in need of mental health care.

V. Findings

JN was an individual with mental illness within the meaning of the Act. The Lynchburg Adult Detention Center operated by BRRJA is a facility within the meaning of the Act. BRRJA failed to carry out an appropriate individual program or treatment plan when it failed to conduct a medical screening of JN in accordance with its policy and procedures and, due to that failure, failed to provide JN a safe environment. It is the opinion of DRVD, therefore, that BRRJA committed neglect as defined in the Act.

A. Definitions

The following definitions are established by the Act:

> For purposes of this subchapter:
>
> (3) The term "facilities" may include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons.

(4) The term "individual with mental illness" means an individual:
(A) who has a significant mental illness or emotional impairment, as determined by a mental health professional qualified under the laws and regulations of the State; and
(B) (i) who is an inpatient or resident in a facility rendering care or treatment, even if the whereabouts of such inpatient or resident are unknown;
(ii) who is in the process of being admitted to a facility rendering care or treatment, including persons being transported to such a facility; or";
(iii) who is involuntarily confined in a municipal detention facility for reasons other than serving a sentence resulting from conviction for a criminal offense.
(5) The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a [sic] individual with mental illness or which placed a [sic] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to a [sic] individual with mental illness, or the failure to provide a safe environment for a [sic] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.
42 U.S.C. § 10802

B. BRRJA Failed to Establish or Carry Out an Appropriate Program Plan or Treatment Plan for JN

The BRRJA Standard Operating Procedure regarding medical screening was not followed. JN had been confined for 6 hours at the time of her death and still had not been processed and medically screened. No effort was made to assess her behavior and appearance or to gather her medical history including current medications.

An adequate medical screening would have raised concerns regarding the number and type of medications that JN had in her possession when received at that jail and would have increased awareness regarding the symptoms that she was exhibiting. An adequate medical screening might also have then triggered the standard operating procedure concerning mental health inmates.

The Booking Report regarding JN dated February 11, 2000 is incomplete and inaccurate. The report indicates that JN was received by an officer who was not on duty at the time that she was received, does not include an Inmate Medical Receiving/ Screening Form, property receipt, or visitation list, and indicates JN's height inaccurately (by 12 inches). These mistakes indicate at best a lack of care and failure to follow established procedures and at worst the production of a record after the fact.

C. BRRJA Failed to Provide a Safe Environment for JN

Despite the fact that JN was in possession of 10 bottles of various medications when she was received, was observed to be groggy and unsteady, and had not revived even after a reported 20-minute walk between cells, no attempt was made to obtain medical assistance or to increase observation.[6]

There was an inordinate delay from the time that JN was discovered to be unresponsive to when resuscitation efforts were begun upon the arrival of the paramedics. There is no evidence to suggest that BRRJA officers did anything to attempt to resuscitate JN.

VI. Recommendations

The following recommendations are made based upon the above findings:

1. BRRJA policy and procedures regarding the prompt medical screening of prisoners should be reemphasized and adherence demanded.

2. BRRJA officers should be trained in CPR.

3. BRRJA officers should have access to and should seek immediate guidance from medical authorities when they receive a prisoner who is taking or is in possession of multiple medications.

4. Inmates who are received for commitment by BRRJA who are in possession of large numbers of prescription medications and who exhibit such symptoms as

[6] Additionally, the receiving officer was informed that JN had cancer. That is, in light of the autopsy report, apparently not true. It was, however, one more factor that should have raised concerns regarding JN's health status.

> grogginess, unsteadiness, and a marked inability to remain awake should be kept under close observation until they can be evaluated by the appropriate medical authority.

On April 10, 2002, draft copies of this Report were sent to BRRJA and JN's next-of-kin. Each party was given the opportunity to submit a response and told that its response would be published with this Report if the comments were received by April 30, 2002.

On April 24, 2002, DRVD received a response from BRRJA and their permission to publish same. Their response is attached as Exhibit A to this Report. No response was received from JN's next-of-kin.

Dated: May 6, 2002

Respectfully Submitted,

Commonwealth of Virginia
Department for Rights of Virginians with Disabilities
202 North 9th Street, 9th Floor
Richmond, VA 23219
(804) 225-3227

By: _____

Paul J. Buckley
Staff Attorney

EXHIBIT A

HEFTY & WILEY, P.C.

WILLIAM H. HEFTY
ROGER C. WILEY
Attorneys at Law

OLD CITY HALL, SUITE 230
1001 EAST BROAD STREET
RICHMOND, VIRGINIA 23219
PHONE: 804 780-3143
FAX: 804 225-8356

April 30, 2002

Paul J. Buckley
Staff Attorney
Department of Rights &of Virginians with Disabilities
202 North 9th Street, 9th Floor
Richmond, VA 23219

Re: DRVD Case #00-0158

Dear Mr. Buckley:

Please accept this letter as the comments of the Blue Ridge Regional Jail Authority to your Report regarding the death of an inmate who was being held at the Blue Ridge Regional Jail. We do not agree that the Jail Authority or its employees were negligent in the inmate's death.

With regard to the Findings contained in your report, while inmates must be medically screened, there is no requirement that the medical screening be accomplished immediately upon a person entering the facility. The booking procedure often takes time, and in this case there were three inmates ahead of the inmate when she arrived at the jail. When she was to be processed, more than two hours after she was brought to the jail, she was drowsy and the booking officer made a decision to not continue with the process. At that time, however, she stated that she was fine and that her medication made her drowsy. Following that time, she was checked at least every 30 minutes and appeared to be sleeping.

The fact that she had several medications in her possession would not have necessarily raised concerns about whether the inmate was in mortal danger. Her medications were taken from her when she was received into the jail, and therefore there was no danger of her taking additional medication. Regarding the booking report, the inmate was received by an officer who was on duty. The fact that the form indicated the name of another officer was a procedural issue which has since been corrected. The other forms were not included because the inmate had not been processed. The discrepancy as to her height was a clerical error.

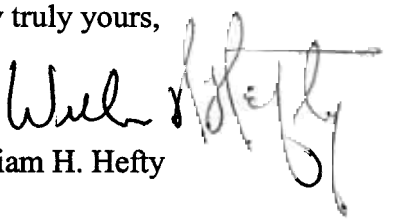
Regarding the issue of whether CPR should have been started earlier, the time between when the officers realized there was a problem and the time the paramedics arrived and actually began CPR was a few minutes. All officers at the jail are trained in CPR, but the officers who initially realized there was a problem were not certain that the inmate was not breathing. They

therefore determined not to begin CPR at that time, which is consistent with their training. Their response, which we feel was appropriate, was to immediately call the nurse and the paramedics. There is certainly no proof that starting CPR any sooner would have changed the outcome.

Regarding the Recommendations that are made in your report, the administration of the jail will continue to reemphasize and stress the prompt medical screening of inmates. As I have indicated, all officers are trained in CPR, and that will continue to be the case. While we disagree that every time an inmate is taking or is in the possession of multiple medications immediate medical guidance should be sought, in the future we will certainly take that into account in determining the medical risk to inmates.

We regret anytime that an inmate dies while in our custody. We feel, however, that in this case such a tragedy was not reasonably foreseeable and that the jail staff was not negligent in their treatment of this inmate.

Very truly yours,



William H. Hefty

WHH/cpj
cc: Christopher R. Webb, Superintendent